



Please complete and sign this form and return with your child(ren)'s Registration Form.

MEDICAL REPORT FORM

Player's Name: _____ Date of Birth: ____/____/____
M D Y

Player's Address: _____ Telephone #: () _____
_____ Postal Code: _____

Health Card #: _____

Name of Parent/Guardian: _____

Please check appropriate boxes:

Comments

Does your child have allergies? Yes No _____

Does your child have asthma? Yes No _____

Does your child have bronchitis? Yes No _____

Does your child have diabetes? Yes No _____

Does your child have epilepsy? Yes No _____

Does your child have problems with vision? Yes No _____

Does your child have problems with hearing? Yes No _____

Is your child required to wear glasses when playing? Yes No _____

Does your child have any heart problems of which you are aware? Yes No _____

Does your child have any orthopedic problems of which you are aware? Yes No _____

Has your child every had a broken bone? Yes No _____

Has your child every had a serious head injury? Yes No _____

Is your child required to take any special medication? Yes No _____

Is there any problem, peculiar to your child and not mentioned above, about which we should be aware? Yes No _____

Should medical assistance be required for the player named on this form, we hereby authorize medical assistance and the use of the above Health Card Number on this form to obtain the required medical assistance.

Date

Signature of Parent/Guardian